Washington State Health Home Model

Hypothetical Chronic Care Management Patient Scenario

Patient Background: "Polly": Polly is divorced, age 59, 5'1" tall and 260 lbs. Polly was first diagnosed with depression at age 17. She was a victim of domestic violence during her first and second marriages and was diagnosed with PTSD at age 38. Additional diagnoses include obesity, arthritis, anxiety disorder and diabetes. Six months ago, Polly developed an incision infection following knee replacement surgery and spent six weeks in a skilled nursing facility. Polly has two adult children living with her; her 40 year old son recently released from prison and her 38 year old daughter, who is developmentally disabled. Polly has recently been accessing routine medical care through the Emergency Room at a local community hospital rather than through a primary care physician. Several local physicians have discontinued care for her due to history of missed appointments.

Engagement and Health Home: There are 2 pathways to initial engagement with Washington's Health Homes for Polly:

1. Based on her chronic conditions and meeting the state's definition of "at risk for another" (a predictive modeling score of 1.5 or higher), she was auto-enrolled with one of the qualified health home designated providers in the geographic region in which she resides. She received outreach and education information sent by mail from the state. The health home designated provider assigned her to a local health home care coordination organization who reached out to Polly to describe the benefits of the service and to determine if she would like to receive health home services.
2. Shortly following Polly's ER visit last week, she was added to a list of persons to be actively sought for engagement by a health home network because she had more than two avoidable emergency room visits in the past fifteen months. This referral came through the local emergency room department who has agreed to refer eligible participants to the program.

The Care Coordination Organization subcontracted with a qualified Health Home designated provider assigned the referral to Betty, a health home care coordinator, to contact Polly and offer care coordination and health home services. Once assigned, the RN care coordinator takes the following steps:

- ✓ Uses the Predictive Risk Intelligence SysteM (PRISM) to review Polly's PRISM claims utilization - 15 month history of care provided by Medicaid and/or Medicare. PRISM information includes episode information related to specific diagnoses or pharmacy utilization; inpatient and outpatient claims, emergency room visits and care, mental health claims, alcohol and other drug treatment claims, pharmacy claims and long-term care assessment data.
- ✓ Makes contact with Polly by phone or mail to arrange a home visit.

The PRISM Health Report indicates that Polly has not been regularly filling prescriptions for her antidepressant or diabetes medications. According to the report, she does not have any prescriptions for her anxiety. She has seen 3 different primary care physicians over the last 15 months, but she has not seen any of them in the past 3 months. Polly has accessed services through the Community Hospital Emergency Room twice in the past three months.

Client Engagement and Enrollment: Polly agrees to participate in Washington's Health Home Services and the Health Home care coordinator:

1. Provides an introduction of the program including a description of care coordination and the Health Home Services;
2. Completes a brief health screening including mental, physical and chemical dependency questionnaires;
3. Evaluates Polly's support system;
4. Completes a ***Consent for Release of Information***
5. Administers and scores the 13-question ***Patient Activation (PAM)*** or ***Caregiver Activation Measure (CAM).***
    a. The PAM measures activation and behaviors that underlie activation including ability to self-manage, to collaborate with providers, to maintain function, prevent declines and to access appropriate and high quality health care.
    b. The PAM helps health home care coordinators to target tools and resources commensurate with the beneficiary's level of activation
    c. The PAM provides insight into how to improve unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health.

The health home care coordinator notes the following healthcare problems by a combined review of PRISM and the initial home visit with Polly:

- ✓ Polly does not have an ongoing relationship with a primary care physician.
- ✓ Polly uses the Community Hospital emergency room for her medical care.
- ✓ Polly's health literacy level is low; she does not have a clear understanding of her diagnoses, of her prescribed medications nor the importance of routine medical care. She admits to having difficulty reading discharge instructions from her recent emergency room visits. She is scored at a low level of activation using the PAM.
- ✓ She was diagnosed with diabetes over one year ago, but has not accessed diabetic education.
- ✓ Polly has a diagnosis of depression and anxiety, but has not filled her anti-depressant medications, has not been prescribed any medication for anxiety in the past 15 months nor does she see a mental health professional.
- ✓ Polly has a limited support system and has a tendency to isolate herself.
- ✓ Polly lacks awareness of tools and resources to help her cope with stress and symptom management.

Health Action Plan Development: During the first home visit, the health home care coordinator introduces the ***Health Action Plan (HAP)*** to Polly; the Health Action Plan helps to guide Polly towards appropriate choices, attainable goals, action steps and improved health. Together, the care coordinator and Polly identify immediate and long-term goals, prioritize concerns and establish immediate action steps. Polly's initial HAP included finding and establishing care with a primary care provider.

Next, the health home care coordinator and Polly complete a ***Goal & Action Planning Worksheet*** to describe what steps Polly would like to take first, to identify possible barriers, her plans to overcome barriers, and to measure how important and how confident Polly feels about this first goal.

Polly's immediate goal is to obtain a primary care provider and a mental health provider. Polly rates this goal as an "8" on a 1-10 scale of importance; however, she rates her confidence in attaining the goal as a "5" on a 1-10 scale of importance. She and her health home care coordinator work together to develop steps that Polly can take now and what steps the health home care coordinator will take to help with this goal and to increase her level of confidence.

Care Coordination: The health home care coordinator sends client a list of providers that are accepting new patients and follows up with a telephone call to the client in 10 days. The client reports she has not contacted any of the providers; she reports she has not left the house since their last visit. The nurse care manager revisits Polly's strengths and support system and coaches her on how to set up an appointment with a new provider. The nurse asked Polly if she thought it would be helpful to prepare a script for her to use when contacting medical providers. Together, they develop a short script Polly has agreed to try with the first three calls she makes. The health home care coordinator also offered to attend her first appointment with her. Polly agreed to make up to three telephone calls that afternoon, but wasn't sure whether she wanted the health home care coordinator to attend an appointment with her.

The health home care coordinator followed up with Polly by telephone; Polly was able to schedule an appointment with a new provider in two weeks; the health home care coordinator completed a new Consent to Release of Information and mailed it to Polly with a return envelope. Upon receipt of the release form, the health home coordinator then mailed the new provider a letter of introduction and the PRISM health report. The health home coordinator set up a tickler to contact Polly two days before the upcoming appointment.

The health home care coordinator contacted Polly two days before her first medical appointment with her new provider; Polly reported she had forgotten about the appointment and had visited the ER over the week-end due to a sore throat. The health home care coordinator congratulated client on taking action regarding her health and promoted the benefits of developing a good relationship with a primary care physician. The health home care coordinator again offered to attend the first visit with Polly and she agreed.

Polly and the health home care coordinator met with Dr. Miller. Dr. Miller had reviewed the PRISM health report and completed an evaluation of Polly's medical and mental health status as well as a review of prescriptions. Dr. Miller referred her for lab work and to a Diabetes educator who provides in-home services and recommended Polly see her monthly for the next three months to better establish her health care. Dr. Miller encouraged Polly to contact her office with any health concerns in between visits.

Maintenance of Health Action Plan: The health home care coordinator continues to work with Polly to promote self-efficacy, review her strengths and successes and to help her achieve her health related goals. After completing the diabetes education class at her home, Polly continues to gain confidence and has identified her next step will be to participating in the Living Well with Chronic Conditions workshop; a workshop designed to help her learn ways to improve her health and to help others in her community.

At the end of the third month Polly has identified as her new immediate goal to have an assessment with a mental health counselor for evaluation of her depression and PTSD. The health home coordinator uses coaching techniques to help Polly identify her action steps for this goal. Polly's plan is to use the same steps she used in establishing her care with a PCP, and is confident she will be successful. Polly has asked her health

home coordinator to provide copies of her recent PRISM Health Report and Health Action Plan to take with her on her first appointment with her mental health counselor.